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BEFORE THE
DENTAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **HYUN SOOK HONG** **425 E. Remington Drive, Suite 2** **Sunnyvale, CA 94087** **Dental License No. 40613** Respondent.	Case Nos. **DBC 2018-55** **ACCUSATION**

Complainant alleges:

PARTIES

1. Karen M. Fischer (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Dental Board of California, Department of Consumer Affairs.

2. On or about November 6, 1992, the Dental Board of California issued Dental License Number 40613 to Hyun Sook Hong (Respondent). The Dental License was in full force and effect at all times relevant to the charges brought in the accusation and will expire on April 30, 2020, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Dental Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 118, subdivision (b), of the Code provides that the suspension, expiration, surrender, or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

STATUTORY PROVISIONS

5. Section 1670 states:

"Any licentiate may have his license revoked or suspended or be reprimanded or be placed on probation by the board for unprofessional conduct, or incompetence, or gross negligence, or repeated acts of negligence in his or her profession, or for the issuance of a license by mistake, or for any other cause applicable to the licentiate provided in this chapter. The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the board shall have all the powers granted therein."

6. Section 1680 states:

"Unprofessional conduct by a person licensed under this chapter [Chapter 4 (commencing with section 1600)] is defined as, but is not limited to, any one of the following:

". . .

"(p) The clearly excessive prescribing or administering of drugs or treatment, or the clearly excessive use of diagnostic procedures, or the clearly excessive use of diagnostic or treatment facilities, as determined by the customary practice and standards of the dental profession.

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"Any person who violates this subdivision is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) or more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days or more than 180 days, or by both a fine and imprisonment.

. . ."

COST RECOVERY

7. Section 125.3, subdivision (a), states, in pertinent part:

"Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department . . . the board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case."

DRUGS

8. Ethylenediaminetetraacetic acid (EDTA) with R-Lipoic Acid is an absorbable form of EDTA that can bind to certain metals, to allow the body to remove metals.

9. Glutathione is a tripeptide protects cells against toxic injury.

10. Gama-aminobutyric acid (GABA) is a natural supplement type of amino acid that induces calm and relaxation.

FACTUAL BACKGROUND

11. On Respondent's website for her practice, she states that she is a "Board Certified Naturopathic Physician." In Respondent's promotional brochure, she uses the title "N.D." as part of her official title to indicate that she is a naturopathic doctor. At the time Respondent described herself as a naturopathic doctor, she did not have a license issued by the Naturopathic Medicine Committee.

Patient S.L.

12. Patient S. L. received treatment from Respondent in 2013 and 2017.

13. On or about September 4, 2013, Respondent treated Patient S.L.'s sore tooth # 3. Respondent took an x-ray of the tooth and diagnosed a lesion on the palatal root. Respondent

provided Patient S.L. with the option of treating the tooth with a root canal or extraction. Respondent recommended extraction and Patient S.L. ultimately chose that option.

14. On or about September 11, 2013, Respondent extracted Patient S.L.'s tooth #3. There were complications with the procedure and on or about September 18, 2013, Respondent performed a root canal on the tooth.

15. Respondent failed to take notes for the treatment that she provided to Patient S.L. on September 11, 2013.

16. On or about October 23, 2013, Respondent put a crown on Patient S.L. tooth #3. Patient S.L. had complications with the crown but delayed going to Respondent for additional treatment because Patient S.L. was undergoing treatment for metastatic breast cancer around the same time period.

17. On September 11, 2013, the same day that Respondent extracted Patient S.L.'s tooth, she also gave Patient S.L. an ozone injection,[1] four ounces of EDTA with R-Lipoic, GABA, 100 mg of glutathione, 100 mg of IMD-intestinal cleanse, and 1.7 ounces of vitamin C + R-Lipoic A. She gave Respondent additional ozone injections on or about September 18, 2013; September 24, 2013; November 12, 2013; February 4, 2014; July 14, 2015; July 21, 2015; and August 5, 2015.

18. Patient S.L. occasionally saw Respondent for dental treatment between 2013 and 2017.

19. On or about March 10, 2017, Patient S.L. returned to Respondent for treatment on tooth #3. Respondent took an x-ray of the tooth. Respondent determined that the molar had a lesion on the palatal root and required a root canal or extraction.

20. Patient S.L. saw a second dentist for a second opinion on how to treat her tooth #3. The second dentist recommended that she see an endodontist.

21. On or about March 27, 2017, Patient S.L. saw an endodontist. The endodontist took an x-ray, tested the tooth with hot and cold applications, and determined that Patient S.L. did not have an abscess and that tooth #3 did not require a root canal treatment.

[1] Ozone therapy is a form of alternative medicine that purports to increase the amount of oxygen in the body through the introduction of ozone. It is sold as an alternative treatment for various illnesses. It is not widely recognized as a viable treatment option for patients.

Patient R.D.

22. On or about June 3, 2014, Patient R.D. went to Respondent for treatment of an existing fistula[2] and infection in the area of her tooth #3.

23. For four months, Respondent treated Patient R.D. with ozone injections and antibiotics.

24. After the ozone and antibiotics failed to alleviate the problem, on or about October 22, 2014, Respondent performed a root canal on Respondent's tooth #3.

25. On or about November 13, 2014, after the root canal was unsuccessful, Respondent performed an extraction on Patient R.D.'s tooth #3. During the extraction procedure, there was extensive bleeding that Respondent had trouble controlling. Respondent did not have the required equipment or supplies to control the bleeding and had to ask her assistant to retrieve additional supplies.

26. Patient R.D.'s infection continued to worsen after the extraction. Patient R.D. made repeated visits to Respondent to treat the infection.

27. On or about February 15, 2015, Patient R.D. awoke to find a large wad of cotton in her mouth at the extraction site. Patient R.D. contacted Respondent about the cotton, and Respondent told Patient R.D. that the cotton was a cotton pellet intentionally left in the extraction site after the extraction. On or about February 16, 2015, Respondent removed two cotton pellets from the extraction site.

28. Patient R.D. had seen Respondent approximately 13 times between the time of the extraction procedure and when Respondent removed the cotton pellets, and Respondent had failed to remove the cotton pellets during any of those visits.

29. After removing the cotton pellets, Respondent continued to treat Patient R.D. with ozone.

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[2] A fistula arises from a dental infection. The bacteria causing the infection can be surrounded by white blood cells, which can result in swelling in and around the infection site. Occasionally the pressure produced by the swelling finds an area of weakness in the soft or hard tissue, and creates a pathway from the infection to the gum tissue. This causes a fistula.

30. On or about March 4, 2016, Patient R.D. had a consultation with an oral surgeon. Patient R.D. underwent oral surgery to complete the following items: extraction of tooth #2, cleaning of the infection in her sinus cavity, repair of the fistula, cleaning of the infection from her palate, bone graft, and removal of the remaining roots left from the extraction of tooth #3.

31. Patient R.D. contacted Respondent for a refund of the payments Patient R.D. had made to Respondent for Respondent's treatment and for the cost of the surgery by the oral surgeon, but Respondent refused.

Patient S.L.

FIRST CAUSE FOR DISCIPLINE
(Gross Negligence)
(Bus. & Prof. Code, § 1670)

32. Respondent has subjected her Dental License to disciplinary action in that she engaged in gross negligence in her treatment of Patient S.L., as set forth in paragraphs 12 to 17, above. (Bus. & Prof. Code, § 1670.) Respondent prescribed medications outside the scope of her dental practice.

SECOND CAUSE FOR DISCIPLINE
(Negligence)
(Bus. & Prof. Code, § 1670)

33. Respondent has subjected her Dental License to disciplinary action in that she engaged in negligence in her treatment of Patient S.L., as set forth in paragraphs 12 to 15, above. (Bus. & Prof. Code, § 1670.) Respondent failed to keep treatment notes for the diagnosis or procedure of the crown replacement of Patient S.L.'s tooth #3.

THIRD CAUSE FOR DISCIPLINE
(Incompetence)
(Bus. & Prof. Code, § 1670)

34. Respondent has subjected her Dental License to disciplinary action in that she engaged in incompetence in her treatment of Patient S.L., as set forth in paragraphs 19 to 21, above. (Bus. & Prof. Code, § 1670.) Respondent diagnosed Patient S.L.'s tooth infection without a clinical examination.

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FOURTH CAUSE FOR DISCIPLINE
(Excessive Prescribing and Administering of Drugs)
(Bus. & Prof. Code, § 1680, subd. (b))

35. Respondent has subjected her Dental License to disciplinary action in that she excessively prescribed and administered drugs in her treatment of Patient S.L., as set forth in paragraphs 12 to 17, above. (Bus. & Prof. Code, § 1670.) Respondent prescribed or distributed multiple ozone injections, EDTA-R-Lipoic, GABA, Glutathione, IMD intestinal cleanse, and vitamin C to Patient S.L., which was an excessive prescription of drugs as determined by customary practice and standards.

Patient R.D.

FIRST CAUSE FOR DISCIPLINE
(Repeated Acts of Gross Negligence)
(Bus. & Prof. Code, § 1670)

36. Respondent has subjected her Dental License to disciplinary action in that she was engaged in repeated acts of gross negligence her treatment of Patient R.D., as set forth in paragraphs 22 to 31, above. (Bus. & Prof. Code, § 1670.) Specifically, Respondent committed the following acts of gross negligence:

a. Offering a non-proven treatment (ozone injections) in a chronic long standing infection without proper discussion and documentation of each option and the advantages and disadvantages of a root canal versus an extraction.

b. Failing to assess and document the progress of her treatment of Patient R.D.'s tooth #3 and failing to make modifications or alterations to the treatment plan to resolve the infection.

c. Untimely referring Patient R.D. to an endodontist after attempting to treatment Patient R.D.'s tooth #3 with a root canal over the course of nine office visits.

d. Failing to properly control and handle excessive bleeding during the root canal she performed on Patient R.D. by failing to have clotting agents or medications available in the office or not knowing where the clotting agents or medications were located.

e. Providing incorrect treatment by leaving non-radio-opaque cotton pellets in the extraction sites in Patient R.D.'s mouth for three months after the extraction procedure.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters alleged in the Accusation, and that following the hearing, the Dental Board of California issue a decision:

1. Revoking or suspending Dental License Number 40613, issued to Hyun Sook Hong;

2. Ordering Hyun Sook Hong to pay the Dental Board of California the reasonable costs of the investigation and enforcement of this case, and, if placed on probation, the costs of probation monitoring; and

3. Taking such other and further action as deemed necessary and proper.

DATED: 2/4/19

Karen M. Fischer

KAREN M. FISCHER
Executive Officer
Dental Board of California
Department of Consumer Affairs
State of California
Complainant

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